

**Student  
Insurance**  
A Division of UICI

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June 21, 2004

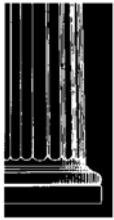
Dear Policyholder:

There are several Federal Laws requiring notices of privacy practices. One such law is the Gramm-Leach-Bliley Act (GLBA) which permits banks, investment companies and insurance companies to provide financial services. This same law requires Student Insurance, a Division of UICI, to share in writing our attached Notice of Privacy Policy and Insurance Information Practices with our policyholders.

Student Insurance has always understood the importance of protecting the confidentiality and security of nonpublic personal information about you and your students that we may possess. We believe that we maintain appropriate physical, electronic and procedural safeguards to maintain the confidentiality and security of your nonpublic personal information. Student Insurance does not sell customer information or share it with outside organizations for their own marketing purposes.

Please feel free to share our Privacy Policy with your students. You can also access our Privacy Policy at our website, [www.studentresources.com](http://www.studentresources.com).

You are a valued policyholder and we thank you for choosing Student Insurance. We appreciate your business.



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## **NOTICE OF PRIVACY POLICY AND INSURANCE INFORMATION PRACTICES**

You are a valued customer of Student Insurance, and we continuously strive to earn and maintain the trust that you have placed in us. Toward that end, we understand the importance of protecting the confidentiality and security of nonpublic personal information about you that we may possess. We have a long history of protecting our customers' privacy.

In order to provide you with financial products of the highest quality and with the service you deserve, it is necessary for us from time to time to collect nonpublic personal information about you and, in certain situations, to share that information with others. The following notice describes our policies and practices with regard to your nonpublic personal information.

### **CONFIDENTIALITY AND SECURITY OF YOUR NONPUBLIC PERSONAL INFORMATION**

We believe that we maintain appropriate physical, electronic and procedural safeguards to maintain the confidentiality and security of your nonpublic personal information. We restrict access to nonpublic personal information about you to those employees who need to know that information to better provide products or services to you.

### **CATEGORIES OF INFORMATION THAT WE MAY COLLECT**

We may collect nonpublic personal information about you from the following sources:

- Information that we receive from you on applications and other forms;
- Information about your transactions with us, our affiliates or others; and
- Information that we receive when you visit us through the Internet.

### **CATEGORIES OF PARTIES TO WHOM WE MAY DISCLOSE INFORMATION**

We may only disclose nonpublic personal financial information about you to nonaffiliated third parties as permitted or required by law.

### **ACCURACY OF YOUR NONPUBLIC PERSONAL INFORMATION THAT WE POSSESS**

We strive to maintain the accuracy of information about you in our possession. In order to help us maintain accuracy, you have the right to reasonably access your information. If you believe any of your information in our possession is inaccurate you may request that we amend or delete the information that you believe to be erroneous. If we concur with your conclusion we will amend or delete the information in question. You may write our Privacy Office at the address below to receive our complete policy on accessing and amending your nonpublic personal information.

### **CHANGES TO OUR NOTICE OF PRIVACY POLICY AND INSURANCE INFORMATION PRACTICES**

We reserve the right to change our privacy policies and insurance information practices. If we make any material changes to our policies or practices we will provide you with a copy of a revised notice.

This notice applies to Student Insurance plans.

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Privacy Office - Student Insurance Division

**GLBA-01**

**2301 West Plano Parkway • Plano, Texas 75075 • 469-229-6700 • 800-767-0700 • FAX 469-229-5699**

# THE MEGA LIFE AND HEALTH INSURANCE COMPANY

Administrative Office Address: P.O. Box 809025, Dallas, TX 75380-9025

<b>POLICYHOLDER</b>	KANSAS STATE SYSTEM	<b>POLICY NUMBER</b>	2004-200118-1
<b>ADDRESS</b>	KANSAS DIVISION OF PURCHASES 900 SW JACKSON STREET, RM 102-N TOPEKA, KANSAS 66612-1286	<b>Effective Date</b>	2004-2005 ACADEMIC YEAR
		<b>Termination Date</b>	2004-2005 ACADEMIC YEAR

## PREMIUM FOR EACH INSURED PERSON

SEE APPLICATION ATTACHED

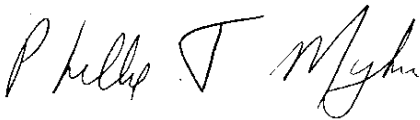
## LIST OF ENDORSEMENTS ATTACHED TO AND FORMING A PART OF THIS POLICY

COL-90-KS END (4A)  
COL-93-KS END (5C)  
COL-90-KS END (8)  
COL-01-KS END (1)  
COL-00 END (2)

## THE MEGA LIFE AND HEALTH INSURANCE COMPANY

hereinafter called the Company, agrees, subject to all provisions, conditions, exclusions and limitations of this policy to pay the benefits provided by this policy for loss resulting from a cause covered by this policy. This policy is issued in consideration of the application and payment of the premiums. Premiums as specified above are payable for each Insured Person.

**Non-Renewable One Year Term Insurance -- This Policy Will Not Be Renewed**



**President**



**Secretary**

Countersigned by \_\_\_\_\_ Licensed Resident Agent

## PREMIUMS AND PREMIUM PAYMENT

The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this policy at any time up to the later of 1) two years after the termination of this policy and 2) the date of final adjustment and settlement of all claims under this policy.

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**PART I**  
**ELIGIBILITY AND TERMINATION PROVISIONS**

**Eligibility:** Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the Application is eligible to be insured under this policy. The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and television (TV) courses do not fulfill the eligibility requirements that the Named Insured actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured (as defined) shall be determined in accordance with the following:

- 1) If a Named Insured has Dependents on the date he or she is eligible for insurance; or
- 2) If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
  - (a) On the date the Named Insured marries the Dependent; or
  - (b) On the date the Named Insured acquires a dependent child who is within the limits of a dependent, unmarried child set forth in the "Definitions" section of this policy.

Dependent eligibility expires concurrently with that of the Named Insured.

Eligible persons may be insured under this policy subject to the following:

- 1) Payment of premium as set forth on the policy application; and,
- 2) Application to the Company for such coverage.

**Effective Date:** Insurance under this policy shall become effective on the later of the following dates:

- 1) The Effective Date of the policy; or
- 2) The date premium is received by the Administrator.

Dependent coverage will not be effective prior to that of the Named Insured.

**Termination Date:** The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid; or
- 2) The date the policy terminates.

The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid;
- 2) The date the policy terminates; or
- 3) The date the Named Insured's coverage terminates.

**PART II**  
**GENERAL PROVISIONS**

**ENTIRE CONTRACT CHANGES:** This policy, including the endorsements, attached papers, and the application, if any, of the Policyholder and the Insured Person shall constitute the entire contract between the parties. Any statement made by the Policyholder or by an Insured Person shall in absence of fraud, be deemed a representation and not a warranty and that no such statement shall be used in defense to a claim under this policy, unless contained in a written application.

The Insured, his or her beneficiary, or assignee, shall have the right to make written request to the Company for a copy of such application, and we shall within fifteen (15) days after receipt of such request at our home office or any branch office, deliver or mail to the person making such request, a copy of the application. If such copy is not delivered or mailed, we shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.

No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto.

## **GENERAL PROVISIONS** *(Continued)*

**PAYMENT OF PREMIUM:** All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the correct premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces. Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment. The Named Insured may purchase optional coverages for themselves or for themselves and all Dependent family members.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809025, Dallas, Texas 75380-9025.

**NOTICE OF CLAIM:** Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

**CLAIM FORMS:** Claim forms are not required.

**PROOF OF LOSS:** Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

**TIME OF PAYMENT OF CLAIM:** Indemnities payable under this policy for any loss will be paid upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All benefits are payable to the Insured, or to their designated beneficiary or beneficiaries, or to their estate, except that if the person insured be a minor, such benefits may be made payable to their parents, guardian, or other person actually supporting them. Subject to any written direction of the Insured, all or a portion of any benefits payable under this policy may be paid directly to the Hospital, Physician or person rendering the service or treatment. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

**PHYSICAL EXAMINATION:** As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

**LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 5 years after the time written proofs of loss are required to be furnished.

**MEMORANDUM OF COVERAGE:** A Memorandum of Coverage shall be issued as required by K.S.A. 40-2210(C).

### **PART III DEFINITIONS**

**ADOPTED CHILD** means the adopted child will be covered from the date the petition for adoption was filed, or from the moment of placement for such adopted child for the first 31 days. The Pre-existing Conditions limitation will not apply to an adoptive child. The Insured must notify the Company, in writing, of the adopted not more than 31 days after placement or adoption.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's date of placement: 1) apply to us; and 2) pay the required additional premium for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.

**COINSURANCE** means the percentage of the allowable charge for a covered service at which payment is made after any applicable Deductible or Copayment amounts have been satisfied.

**COMPLICATION OF PREGNANCY** means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct Complication of Pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a Complication of Pregnancy. The term "Complication of Pregnancy" includes non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; hyperemesis gravidarum; and, pre-eclampsia.

**COPAYMENT OR COPAY** means the amount to be paid by the Member before benefits can be provided for a covered service. A Copayment is required each time a specific service such as a lab test is provided. A Copayment does not accumulate toward a specified maximum.

**COVERED MEDICAL EXPENSES** means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

**DEDUCTIBLE** means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a Deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The Deductible will apply per policy year or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

**DEPENDENT** means the spouse (husband or wife) of the Named Insured and their dependent, unmarried children. Children shall cease to be dependent on the first to occur of:

- 1) The end of the month in which they marry; or,
- 2) The end of the month in which they attain the age of nineteen (19) years; or 23 years, if a full-time dependent student at an accredited institution of higher learning.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

- 1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and,
- 2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

**ELECTIVE AND EXPERIMENTAL SURGERY AND TREATMENT** means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective Surgery or Elective Treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

## **DEFINITIONS (Continued)**

**HOSPITAL** means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

**HOSPITAL CONFINED/HOSPITAL CONFINEMENT** means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

**INJURY** means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

**INSURED PERSON** means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate dependent premium has been paid. The term "Insured" also means Insured Person.

**INTENSIVE CARE** means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care does not mean any of these step-down units:

- 1) Progressive care;
- 2) Sub-acute intensive care;
- 3) Intermediate care units;
- 4) Private monitored rooms;
- 5) Observation units; or
- 6) Other facilities which do not meet the standards for Intensive Care.

**MEDICAL EMERGENCY** means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in:

- 1) Death;
- 2) Placement of the Insured's health in jeopardy;
- 3) Serious impairment of bodily functions;
- 4) Serious dysfunction of any body organ or part; or
- 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

**MEDICAL NECESSITY** means those services or supplies provided or prescribed by a Hospital or Physician which are:

- 1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury;
- 2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury;
- 3) In accordance with the standards of good medical practice; and,
- 4) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which in the judgment of the Company are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.



## **DEFINITIONS** *(Continued)*

**MENTAL AND NERVOUS DISORDER** means disorders specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, 1994).

**NAMED INSURED PERSON** means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid. The term "Insured" also means Insured Person.

**NEWBORN INFANT** means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to us; and 2) pay the required additional premium for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

**PHYSICIAN** means a health care provider who is: 1) duly licensed under the Kansas Healing Arts Act; 2) acting within his/her lawful scope of practice; and 3) not a member of the Insured Person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

**PHYSIOTHERAPY** means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

**PRE-EXISTING CONDITION** means 1) the existence of symptoms within the 180 days immediately prior to the Insured's effective date under the policy; 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 180 days immediately prior to the Insured's effective date under the policy. Pre-Existing Conditions will not be covered under this policy until the Insured has been covered under the plan for 8 months.

**PRESCRIPTION DRUGS** means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

**PSYCHOTHERAPY** means the treatment of a Mental and Nervous Disorder. Psychotherapy must be administered by an M.D.; or licensed psychologist, Ph.D.; or licensed Specialist Social Worker. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.

**REGISTERED NURSE** means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

**SICKNESS** means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness.

**SOUND NATURAL TEETH** means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

**USUAL AND CUSTOMARY CHARGES** means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges. The data that is used to determine the Usual and Customary Charges is updated at least every six months.

**PART IV**  
**EXTENSION OF BENEFITS AFTER TERMINATION**

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 30 days after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

**PART V**  
**SCHEDULE OF BENEFITS**  
**BASIC MEDICAL EXPENSE BENEFITS - INJURY**  
**KANSAS STATE SYSTEM**  
**PREFERRED PROVIDERS**  
**2004-200118-1**  
**INJURY ONLY**

<b>Maximum Benefit</b>	<b>\$100,000.00 (Per Policy Year)</b>
<b>Deductible</b>	<b>\$500.00 (Per Insured Person) (Per Policy Year)</b> <b>(\$1,500.00 maximum Deductible per family)</b>
<b>Coinsurance</b>	<b>80% except as noted below</b>

The Policy provides benefits for the Usual and Customary Charges (UCC) incurred by an Insured Person for loss due to a covered Injury. If you receive care from a Preferred Provider, any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. See Preferred Provider information on page 8 (3). If a Preferred Provider is not available in your Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expenses are incurred due to an emergency treatment, benefits will be paid at the Preferred Provider level of Benefits. In all other situations, reduced, or lower benefits will be provided when an Out-of-Network provider is used. The Benefits payable are as defined in and subject to all provisions of this Policy and any endorsements thereto.

Benefits will be paid up to the Maximum Benefit for each service scheduled below. After the Deductible has been satisfied, benefits will be paid as listed for the Provider selected. Maximum total benefits are \$100,000.00 Per Policy Year.

Usual and Customary Charges will be calculated based on the 80th percentile of Ingenix, Inc.

The Deductible will be waived and benefits paid at 100% for treatment rendered for Covered Medical Expenses at the Student Health Center. A \$5.00 copayment will apply for all lab procedures at the Student Health Center. The outpatient Prescription Drug annual maximum benefit of \$250.00 applies at the Student Health Center.

**Inpatient**

Room & Board:	100% of Allowable Charges / \$300.00 per day
Intensive Care:	Paid under Room and Board Benefit
Hospital Miscellaneous:	Allowable Charges
Physiotherapy:	Allowable Charges
Surgery:	Allowable Charges
<i>(In accordance with data provided by Ingenix, Inc.)</i>	
Assistant Surgeon:	75% of surgery allowance
Anesthetist:	Allowable Charges
Registered Nurse:	Allowable Charges
Physician's Visits:	Allowable Charges
Pre-admission Testing:	Allowable Charges

**Outpatient**

Surgery:	Allowable Charges
<i>(In accordance with data provided by Ingenix, Inc.)</i>	
Day Surgery Miscellaneous:	Allowable Charges
Anesthetist:	Allowable Charges
Assistant Surgeon:	75% of surgery allowance
Outpatient Miscellaneous Benefit:	No Benefits
Physician's Visits:	Allowable Charges
<i>(One visit per day.)</i>	
Physiotherapy:	Allowable Charges
Medical Emergency:	Allowable Charges
<i>(\$50 copayment per visit. This is in addition to the Policy Deductible. The Deductible will be waived if admitted.)</i>	

**PART V (Continued)**  
**SCHEDULE OF BENEFITS**  
**BASIC MEDICAL EXPENSE BENEFITS - INJURY**  
**KANSAS STATE SYSTEM**  
**PREFERRED PROVIDERS**  
**2004-200118-1**  
**INJURY ONLY**

**Outpatient (Continued)**

X-Rays	Allowable Charges
Laboratory:	Allowable Charges
<i>(A \$5.00 copayment will apply for all lab procedures at the Student Health Center.)</i>	
Tests & Procedures:	Allowable Charges
Injections:	Allowable Charges
Prescription Drugs:	Usual & Customary Charges / \$250.00 maximum

**Other**

Ambulance:	Allowable Charges
Braces & Appliances:	Allowable Charges
Consultant:	Allowable Charges
Dental:	100% of Usual & Customary Charges / \$500.00 maximum
<i>(Benefits paid on Injury to Sound, Natural Teeth only.)</i>	
Repatriation:	Benefit Provided by Assist America.
Medical Evacuation:	Benefit Provided by Assist America.

**MAJOR MEDICAL**  
**Included ( ) Optional (X)**

<b>Maximum Benefit</b>	<b>\$100,000.00 (Per Policy Year)</b>
<b>Total Benefit Basic &amp; Major Medical</b>	<b>\$200,000.00 (Per Policy Year)</b>
<b>Deductible</b>	<b>- 0 -</b>
<b>Coinsurance</b>	<b>100%</b>

(as described in the Major Medical Benefit endorsement attached)

**SHC Referral Required:** Yes ( ) No (X)

**Conversion Permitted:** Yes ( ) No (X)

( ) **52 week Benefit Period** or (X) **Extension of Benefits**

**Other Insurance:** (X) **\*Coordination of Benefits** ( ) **Primary Insurance**

\*If benefit is designated, see endorsement attached.

**PART V**  
**SCHEDULE OF BENEFITS**  
**BASIC MEDICAL EXPENSE BENEFITS - SICKNESS**  
**KANSAS STATE SYSTEM**  
**PREFERRED PROVIDERS**  
**2004-200118-1**  
**SICKNESS ONLY**

<b>Maximum Benefit</b>	<b>\$100,000.00 (Per Policy Year)</b>
<b>Deductible</b>	<b>\$500.00 (Per Insured Person) (Per Policy Year)</b> <b>(\$1,500.00 maximum Deductible per family)</b>
<b>Coinsurance</b>	<b>80% except as noted below</b>

The Policy provides benefits for the Usual and Customary Charges (UCC) incurred by an Insured Person for loss due to a covered Sickness. If you receive care from a Preferred Provider, any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. See Preferred Provider information on page 8 (3). If a Preferred Provider is not available in your Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expenses are incurred due to an emergency treatment, benefits will be paid at the Preferred Provider level of Benefits. In all other situations, reduced, or lower benefits will be provided when an Out-of-Network provider is used. The Benefits payable are as defined in and subject to all provisions of this Policy and any endorsements thereto.

Benefits will be paid up to the Maximum Benefit for each service scheduled below. After the Deductible has been satisfied, benefits will be paid as listed for the Provider selected. Maximum total benefits are \$100,000.00 Per Policy Year.

Usual and Customary Charges will be calculated based on the 80th percentile of Ingenix, Inc.

The Deductible will be waived and benefits paid at 100% for treatment rendered for Covered Medical Expenses at the Student Health Center. A \$5.00 copayment will apply for all lab procedures at the Student Health Center. The outpatient Prescription Drug annual maximum benefit of \$250.00 applies at the Student Health Center.

Benefits are provided for a chest X-ray when required as a result of a TB test required by the school, payable at 100% up to \$50.00 per X-ray.

**Inpatient**

Room & Board:	100% of Allowable Charges / \$300.00 per day
Intensive Care:	Paid under Room and Board Benefit
Hospital Miscellaneous:	Allowable Charges / \$1,500.00 aggregate maximum per day
Physiotherapy:	Paid under Hospital Miscellaneous Benefit
Surgery:	100% of Allowable Charges
<i>(In accordance with data provided by Ingenix, Inc.)</i>	
Assistant Surgeon:	75% of Surgery allowance
Anesthetist:	75% of Surgery allowance
Registered Nurse:	Allowable Charges
Physician's Visits:	\$30.00 per day / 30 days maximum (for each Sickness)
Pre-admission Testing:	Paid under Hospital Miscellaneous Benefit
*Psychotherapy:	Paid as any other Sickness / 30 days maximum (Per Policy Year)

**Outpatient**

Surgery:	100% of Allowable Charges
<i>(In accordance with data provided by Ingenix, Inc.)</i>	
Day Surgery Miscellaneous:	Allowable Charges / \$4,000.00 maximum (For each Sickness)
Anesthetist:	75% of Surgery allowance
Assistant Surgeon:	75% of Surgery allowance
Outpatient Miscellaneous Benefit:	Allowable Charges / \$2,500.00 maximum (For each Sickness)
Physician's Visits:	\$30.00 per day / 5 days maximum
Physiotherapy:	Paid under Physician Visits Benefit
Medical Emergency:	Paid under Outpatient Miscellaneous Benefit
<i>(\$50 copayment per visit. This is in addition to the Policy Deductible. The Deductible will be waived if admitted.)</i>	

**PART V (Continued)**  
**SCHEDULE OF BENEFITS**  
**BASIC MEDICAL EXPENSE BENEFITS - SICKNESS**  
**KANSAS STATE SYSTEM**  
**PREFERRED PROVIDERS**  
**2004-200118-1**  
**SICKNESS ONLY**

**Outpatient (Continued)**

X-Rays	Paid under Outpatient Miscellaneous Benefit
Laboratory:	Paid under Outpatient Miscellaneous Benefit
<i>(A \$5.00 copayment will apply for all lab procedures at the Student Health Center.)</i>	
Radiation Therapy:	Paid under Optional Major Medical Benefit, if purchased
Tests & Procedures:	Paid under Outpatient Miscellaneous Benefit
Injections:	No Benefits
Chemotherapy:	Paid under Optional Major Medical Benefit, if purchased
Prescription Drugs:	100% of Usual & Customary Charges / \$250.00 maximum
<i>(Birth control pills are covered up to a maximum of \$7.50 per month.</i>	
<i>Depo Provera is covered up to a maximum of \$22.50 every 3 months.)</i>	
*Psychotherapy:	100% of Usual & Customary Charges for the first \$100.00; 80% for the next \$100.00; and 50% for the next \$1,640.00 in any Policy Year / \$7,500.00 Maximum Lifetime Benefit

**Other**

Ambulance:	\$150.00 maximum
Braces & Appliances:	No Benefits
Consultant:	\$150.00 maximum
Dental:	No Benefits
Repatriation:	Benefit Provided by Assist America.
Medical Evacuation:	Benefit Provided by Assist America.
Maternity:	Paid as any other Sickness
Complications of Pregnancy:	Paid as any other Sickness

**MAJOR MEDICAL**  
**Included ( ) Optional (X)**

<b>Maximum Benefit</b>	<b>\$100,000.00 (Per Policy Year)</b>
<b>Total Benefit Basic &amp; Major Medical</b>	<b>\$200,000.00 (Per Policy Year)</b>
<b>Deductible</b>	<b>- 0 -</b>
<b>Coinsurance</b>	<b>100%</b>

(as described in the Major Medical Benefit endorsement attached)

**SHC Referral Required:** Yes ( ) No (X)

**Conversion Permitted:** Yes ( ) No (X)

( ) **52 week Benefit Period** or (X) **Extension of Benefits**

**Other Insurance:** (X) **\*Coordination of Benefits** ( ) **Primary Insurance**

\*If benefit is designated, see endorsement attached.

**PART V**  
**SCHEDULE OF BENEFITS**  
**BASIC MEDICAL EXPENSE BENEFITS - INJURY**  
**KANSAS STATE SYSTEM**  
**OUT OF NETWORK PROVIDERS**  
**2004-200118-1**  
**INJURY ONLY**

<b>Maximum Benefit</b>	<b>\$100,000.00 (Per Policy Year)</b>
<b>Deductible</b>	<b>\$500.00 (Per Insured Person) (Per Policy Year)</b> <b>(\$1,500.00 maximum Deductible per family)</b>
<b>Coinsurance</b>	<b>60% except as noted below</b>

The Benefits payable are as defined in and subject to all provisions of this Policy and any endorsements thereto.

Usual and Customary Charges will be calculated based on the 80th percentile of Ingenix, Inc.

The Deductible will be waived and benefits paid at 100% for treatment rendered for Covered Medical Expenses at the Student Health Center. A \$5.00 copayment will apply for all lab procedures at the Student Health Center. The outpatient Prescription Drug annual maximum benefit of \$250.00 applies at the Student Health Center.

**Inpatient**

Room & Board:	100% of Usual & Customary Charges / \$300.00 per day
Intensive Care:	Paid under Room and Board
Hospital Miscellaneous:	Usual & Customary Charges
Physiotherapy:	Usual & Customary Charges
Surgery:	Usual & Customary Charges
<i>(In accordance with data provided by Ingenix, Inc.)</i>	
Assistant Surgeon:	75% of Surgery allowance
Anesthetist:	Usual & Customary Charges
Registered Nurse:	Usual & Customary Charges
Physician's Visits:	Usual & Customary Charges
Pre-admission Testing:	Usual & Customary Charges

**Outpatient**

Surgery:	Usual & Customary Charges
<i>(In accordance with data provided by Ingenix, Inc.)</i>	
Day Surgery Miscellaneous:	Usual & Customary Charges
Anesthetist:	Usual & Customary Charges
Assistant Surgeon:	75% of Surgery allowance
Outpatient Miscellaneous Benefit:	No Benefits
Physician's Visits:	Usual & Customary Charges
<i>(One visit per day.)</i>	
Physiotherapy:	Usual & Customary Charges
Medical Emergency:	Usual & Customary Charges
<i>(Additional \$50 copayment per visit. This is in addition to the Policy Deductible. The Deductible will be waived if admitted.)</i>	
X-Rays	Usual & Customary Charges
Laboratory:	Usual & Customary Charges
<i>(A \$5.00 copayment will apply for all lab procedures at the Student Health Center.)</i>	
Tests & Procedures:	Usual & Customary Charges
Injections:	Usual & Customary Charges
Prescription Drugs:	Usual & Customary Charges / \$250.00 maximum

**Other**

Ambulance:	Usual & Customary Charges
Braces & Appliances:	Usual & Customary Charges
Consultant:	Usual & Customary Charges
Dental:	100% of Usual & Customary Charges / \$500.00 maximum
<i>(Benefits paid on Injury to Sound, Natural Teeth only)</i>	
Repatriation:	Benefit Provided by Assist America.
Medical Evacuation:	Benefit Provided by Assist America.

**PART V (Continued)**  
**SCHEDULE OF BENEFITS**  
**BASIC MEDICAL EXPENSE BENEFITS - INJURY**  
**KANSAS STATE SYSTEM**  
**OUT OF NETWORK PROVIDERS**  
**2004-200118-1**  
**INJURY ONLY**

**MAJOR MEDICAL**  
**Included ( ) Optional (X)**

<b>Maximum Benefit</b>	<b>\$100,000.00 (Per Policy Year)</b>
<b>Total Benefit Basic &amp; Major Medical</b>	<b>\$200,000.00 (Per Policy Year)</b>
<b>Deductible</b>	<b>- 0 -</b>
<b>Coinsurance</b>	<b>100%</b>

(as described in the Major Medical Benefit endorsement attached)

**SHC Referral Required:** Yes ( ) No (X)

**Conversion Permitted:** Yes ( ) No (X)

( ) **52 week Benefit Period** or (X) **Extension of Benefits**

**Other Insurance:** (X) **\*Coordination of Benefits** ( ) **Primary Insurance**

\*If benefit is designated, see endorsement attached.



**PART V**  
**SCHEDULE OF BENEFITS**  
**BASIC MEDICAL EXPENSE BENEFITS - SICKNESS**  
**KANSAS STATE SYSTEM**  
**OUT OF NETWORK PROVIDERS**  
**2004-200118-1**  
**SICKNESS ONLY**

<b>Maximum Limited Benefit</b>	<b>\$100,000.00 (Per Policy Year)</b>
<b>Deductible</b>	<b>\$500.00 (Per Insured Person) (Per Policy Year)</b> <b>(\$1,500.00 maximum Deductible per family)</b>
<b>Coinsurance</b>	<b>60% except as noted below</b>

The Benefits payable are as defined in and subject to all provisions of this Policy and any endorsements thereto.

Usual and Customary Charges will be calculated based on the 80th percentile of Ingenix, Inc.

The Deductible will be waived and benefits paid at 100% for treatment rendered for Covered Medical Expenses at the Student Health Center. A \$5.00 copay will apply for all lab procedures at the Student Health Center. The outpatient Prescription Drug annual maximum benefit of \$250.00 applies at the Student Health Center.

Benefits are provided for a chest X-ray when required as a result of a TB test required by the school, payable at 100% up to \$50.00 per X-ray.

**Inpatient**

Room & Board:	100% of Usual & Customary Charges / \$300.00 per day
Intensive Care:	Paid under Room and Board
Hospital Miscellaneous:	Usual & Customary Charges / \$1,500.00 aggregate maximum per day
Physiotherapy:	Paid under Hospital Miscellaneous Benefit
Surgery:	Usual & Customary Charges
<i>(In accordance with data provided by Ingenix, Inc.)</i>	
Assistant Surgeon:	75% of Surgery allowance
Anesthetist:	75% of Surgery allowance
Registered Nurse:	Usual & Customary Charges
Physician's Visits:	\$30.00 per day / 30 days maximum (for each Sickness)
Pre-admission Testing:	Paid under Hospital Miscellaneous Benefit
*Psychotherapy:	Paid as any other Sickness / 30 days maximum (Per Policy Year)

**Outpatient**

Surgery:	Usual & Customary Charges
<i>(In accordance with data provided by Ingenix, Inc.)</i>	
Day Surgery Miscellaneous:	Usual & Customary Charges / \$4,000.00 maximum (For each Sickness)
Anesthetist:	75% of Surgery allowance
Assistant Surgeon:	75% of Surgery allowance
Outpatient Miscellaneous Benefit:	Usual & Customary Charges / \$2,500.00 maximum (For each Sickness)
Physician's Visits:	\$30.00 per day / 5 days maximum
Physiotherapy:	Paid under Physician Visits
Medical Emergency:	Paid under Outpatient Miscellaneous Benefit
<i>(Additional \$50 copayment per visit. This is in addition to the Policy Deductible. The Deductible will be waived if admitted.)</i>	
X-Rays & Laboratory:	Paid under Outpatient Miscellaneous Benefit
Radiation Therapy:	Paid under Optional Major Medical Benefit, if purchased
Tests & Procedures:	Paid under Outpatient Miscellaneous Benefit
Injections:	No Benefits
Chemotherapy:	Paid under Optional Major Medical Benefit, if purchased
Prescription Drugs:	100% of Usual & Customary Charges / \$250.00 maximum
<i>(Birth control pills are covered up to a maximum of \$7.50 per month.</i>	
<i>Depo Provera is covered up to a maximum of \$22.50 every 3 months.)</i>	
*Psychotherapy:	100% of Usual & Customary Charges for the first \$100.00; 80% for the next \$100.00; and 50% for the next \$1,640.00 in any Policy Year / \$7,500.00 Maximum Lifetime Benefit

**PART V (Continued)**  
**SCHEDULE OF BENEFITS**  
**BASIC MEDICAL EXPENSE BENEFITS - SICKNESS**  
**KANSAS STATE SYSTEM**  
**OUT OF NETWORK PROVIDERS**  
**2004-200118-1**  
**SICKNESS ONLY**

**Other**

Ambulance:	\$150.00 maximum
Braces & Appliances:	No Benefits
Consultant:	\$150.00 maximum
Dental:	No Benefits
Repatriation:	Benefit Provided by Assist America.
Medical Evacuation:	Benefit Provided by Assist America.
Maternity:	Paid as any other Sickness
Complications of Pregnancy:	Paid as any other Sickness

**MAJOR MEDICAL**  
**Included ( ) Optional (X)**

<b>Maximum Benefit</b>	<b>\$100,000.00 (Per Policy Year)</b>
<b>Total Benefit Basic &amp; Major Medical</b>	<b>\$200,000.00 (Per Policy Year)</b>
<b>Deductible</b>	<b>- 0 -</b>
<b>Coinsurance</b>	<b>100%</b>

(as described in the Major Medical Benefit endorsement attached)

**SHC Referral Required:** Yes ( ) No (X)

**Conversion Permitted:** Yes ( ) No (X)

( ) **52 week Benefit Period** or (X) **Extension of Benefits**

**Other Insurance:** (X) **\*Coordination of Benefits** ( ) **Primary Insurance**

\*If benefit is designated, see endorsement attached.

**PART V (Continued)**  
**SCHEDULE OF BENEFITS**  
**BASIC MEDICAL EXPENSE BENEFITS – INJURY AND SICKNESS**  
**KANSAS STATE SYSTEM**  
**2004-200118-1**

**PREFERRED PROVIDER INFORMATION**

**“Preferred Providers”** are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in your local school area are in the WPPA Network, Newman Memorial County Hospital, Hays Medical Center, Mercy Health Center, Via Christi Rehabilitation Center, Wesley, and Lawrence Memorial Hospital.

The availability of specific providers is subject to change without notice. You should always confirm that a Preferred Provider is participating at the time services are required by calling us at 1-800-767-0700, on the website at [www.wppainc.com](http://www.wppainc.com) and/or by asking the provider when you make an appointment for services.

**“Preferred Allowance”** means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

**“Out of Network”** providers have not agreed to any prearranged fee schedules. You may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are your responsibility.

**“Allowable Charges”** means The MEGA Life and Health Insurance Company’s allowance for a specified Covered Medical Expense or the Provider’s charge for the service, whichever is less.

Regardless of the provider, you are responsible for the payment of your Deductible. You must satisfy your Deductible before benefits are paid. We will pay according to the benefit limits in the Schedule of Medical Expense Benefits.

**PART VI**  
**MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS**

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations."

If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged for by the Hospital.
2. **Intensive Care:** If provided in the Schedule of Benefits.
3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests, including pap smears; X-ray examinations, including mammograms; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
4. **Physiotherapy (Inpatient):** See Schedule of Benefits.
5. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered Medical Expenses will be paid under this inpatient surgery benefit; or under the outpatient surgery benefit, but not both. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable.
6. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.
7. **Anesthetist Services:** in connection with inpatient surgery.
8. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
9. **Physician's Visits:** when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.
10. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.
11. **Psychotherapy (Inpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits. Benefits are limited to one visit per day.
12. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered Medical Expenses will be paid under this outpatient surgery benefit; or under the inpatient surgery benefit, but not both. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable.

## MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS (Continued)

13. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.
14. **Anesthetist (Outpatient):** in connection with outpatient surgery.
15. **Outpatient Miscellaneous Benefit:** outpatient Hospital and Physician services. Outpatient services payable under this benefit will be designated "Paid under Outpatient Miscellaneous Benefit" in the Schedule of Benefits.
16. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.
17. **Physiotherapy (Outpatient):** benefits are limited to one visit per day.
18. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the attending Physician's charges, X-rays, laboratory procedures, injections, the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.
19. **Diagnostic X-ray Services (Outpatient):** coverage shall include benefits for mammograms under this benefit when performed by or at the direction of a Physician. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.
20. **Radiation Therapy (Outpatient):** See Schedule of Benefits.
21. **Laboratory Procedures (Outpatient):** coverage shall include benefits for pap smears under this benefit when performed by or at the direction of a Physician. Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
22. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.
23. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.
24. **Chemotherapy (Outpatient):** See Schedule of Benefits.
25. **Prescription Drugs (Outpatient):** See Schedule of Benefits.
26. **Psychotherapy (Outpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits. Benefits are limited to one visit per day.
27. **Ambulance Services:** See Schedule of Benefits.
28. **Braces and Appliances:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable, medical equipment which is equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.
29. **Consultant Physician Fees:** when requested and approved by the attending Physician. Covered Medical Expenses will be paid under this benefit or under the Physician's Visits benefit, but not both on the same day.
30. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Routine dental care and treatment to the gums are not covered.

**MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS** *(Continued)*

- 31. **Alcoholism/Drug Abuse Treatment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.
- 32. **Maternity:** Same as any other Sickness.
- 33. **Routine Well-Baby Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. The benefits and the maximum amounts are specified in the Schedule of Benefits.
- 34. **Complications of Pregnancy:** Same as any other Sickness.
- 35. **Repatriation:** If the Insured dies while insured under the Policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. No additional benefits will be paid under Basic or Major Medical coverage.
- 36. **Medical Evacuation:** 1) when Hospital Confined for at least five consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. No additional benefits will be paid under Basic or Major Medical coverage.

## **PART VII MATERNITY TESTING**

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered, if all other policy provisions have been met. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: Amniocentesis/AFP Screening, and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. Pre-natal vitamins are not covered.

## **PART VIII BENEFITS FOR CHILDHOOD IMMUNIZATIONS**

Benefits will be provided on the same basis as for any other Sickness for immunizations for children from birth to 72 months of age. Immunizations shall consist of at least five doses of vaccine against diphtheria, pertussis, tetanus; at least four doses of vaccine against polio and Haemophilus B (Hib); and three doses of vaccine against Hepatitis B; two doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella and such other vaccines and dosages as may be prescribed by the secretary of health and environment.

Benefits shall not be subject to any Deductible, copayment or coinsurance requirements.

## **PART IX DIABETES BENEFIT**

Benefits will be provided for all Medically Necessary equipment, supplies, and diabetes self-management training and educational services used to treat diabetes, if a Physician certifies that such services are Medically Necessary. If prescription drugs are provided under the Schedule of Benefits, insulin is also provided under this section. Diabetes self-management training, educational services and nutrition counseling must be provided under the direct supervision of a Physician.

**"Diabetes self-management training"** means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

These benefits shall be provided to the same extent as for any other Sickness under the Policy and subject to all Deductible, coinsurance, limitations and provisions of the Policy.

## **PART X CYTOLOGIC SCREENING AND MAMMOGRAPHY BENEFIT**

Benefits shall be provided on the same basis as any other Sickness for mammograms, cytologic screening, or (pap) smears when performed at the direction of a Physician. Benefits shall be subject to all Deductibles, coinsurance, limitations and provisions of the Policy.

## **PART XI BENEFITS FOR BREAST RECONSTRUCTION FOLLOWING A MASTECTOMY**

Benefits will be paid the same as any other Sickness for Insureds who elect breast reconstruction in connection with a mastectomy. Benefits include:

- (1) reconstruction of the breast on which the mastectomy was performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (3) prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy.

**PART XII**  
**GENERAL ANESTHESIA AND MEDICAL CARE FACILITY COVERAGE FOR DENTAL CARE BENEFIT**

Benefits shall be provided on the same basis as any other Sickness for the administration of general anesthesia and medical care facility charges for dental care provided to the following Insureds:

- (1) A Dependent child five years of age and under; or
- (2) An Insured who is severely disabled; or
- (3) An Insured that has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Benefits shall be subject to the same deductibles, coinsurance, network requirements and other limitations, including but not limited to Medical Necessity determinations, as apply to other Policy provisions.

**PART XIII**  
**BENEFITS FOR OSTEOPOROSIS**

Benefits will be paid the same as any other Sickness for Insureds with a condition or medical history for which bone mass measurement is medically necessary. Benefits include services for the diagnosis, treatment and management of osteoporosis when provided by a Physician.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy.



**PART XIV**  
**EXCLUSIONS AND LIMITATIONS**

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

1. Automobile Excess- No payment will be made for Hospital, medical or other health services resulting from accidental bodily Injury arising out of a motor vehicle accident to the extent that benefits are payable under any medical expense payment provision of any automobile insurance policy, including such benefits mandated by law;
2. Congenital conditions, except as specifically provided for Newborn or adopted Infants; circumcision;
3. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
4. Custodial Care services and supplies related to custodial care such as care provided in rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or custodial care. Extended care in treatment or substance abuse facilities also are not covered for domiciliary or custodial care;
5. Acne; acupuncture; allergy antigen treatment and allergy testing; alopecia; biofeedback-type services; breast implants; breast reduction; corns, calluses and bunions; deviated nasal septum; gynecomastia; hirsutism; learning disabilities; nasal and sinus surgery; nicotine addiction; nonmalignant warts, moles and lesions for cosmetic reasons; obesity and any condition resulting therefrom; patient controlled analgesia (PCA); skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing thereof; temporomandibular joint dysfunction; Elective and Experimental Surgery and Treatment;
6. Injury sustained while (a) participating in any intercollegiate sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
7. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
8. Immunizations services and supplies related to immunizations, except as specifically provided in a benefit section; preventive medicines or vaccines, except where required for treatment of a covered Injury;
9. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
10. Pre-existing Conditions except for: 1) individuals who have been continuously insured for at least 8 months under any plan as defined under Creditable Prior Coverage if the previous coverage was continuous to a date not more than 63 days prior to the Insured's Effective Date under the Policy; or 2) individuals who have been continuously insured for at least 8 months under the school's student insurance policy; or 3) a child that is adopted or placed for adoption before attaining eighteen years of age.

"Creditable Prior Coverage" means any individual or group policy, contract or program provided by an HMO, Insurer, self-insured employer plan or any other entity that arranges or provides medical, hospital or surgical coverage, not designed to supplement other private or governmental plans. It should include prior coverage under a group or individual sickness and accident policy, provided by a government plan (such as Medicaid and Medicare) COBRA, CHAMPUS, the Federal Employee Health Benefits Plan, Peace Corps Plans, the Indian Health Service, coverage provided through state high risk pools and other public plans.

Covered person who have been insured under a coverage as defined in Creditable Prior Coverage and have no gap in such coverage that exceeds 63 days immediately prior to enrollment in this plan will receive the applicable amount of credit for prior coverage. If a covered person has 8 months prior creditable coverage with no gap in coverage exceeding 63 days immediately prior to enrollment in this plan the pre-existing limitation is satisfied.

## **EXCLUSIONS AND LIMITATIONS** *(Continued)*

11. Prescription Drug Services - no benefits will be payable for:
  - a) Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use;
  - b) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
  - c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for drugs for the treatment of cancer that are a recognized treatment in one of the standard reference compendia or in substantially accepted peer reviewed medical literature;
  - d) Products used for unapproved cosmetic indications;
  - e) Drugs used to treat or cure baldness, and anabolic steroids used for body building;
  - f) Anorectics - drugs used for the purpose of weight control;
  - g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
  - h) Growth hormones; or
  - i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
12. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery;
13. Routine Newborn Infant care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery; except as specifically provided in the Policy;
14. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the Policy;
15. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
16. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
17. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
18. Vision services and supplies related to eye refractions or eye examinations, eyeglasses or contact lenses or prescriptions or fitting of eyeglasses, and radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or service except when due to a disease process; and
19. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

# POLICY ENDORSEMENT

**In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:**

## OPTIONAL MAJOR MEDICAL BENEFIT

This optional benefit is subject to payment of an additional premium. The additional premium is specified on the policy face page.

The Optional Major Medical Benefit begins payment after the Basic Maximum Benefit of \$100,000.00 has been paid by the Company.

The Company will pay 100% of additional, incurred Covered Medical Expenses after first deducting the Basic Maximum Benefit. Payment will not exceed the Major Medical Maximum Benefit of \$200,000.00 per Policy Year.

The total amount payable by the Company under this endorsement for all Injury or Sickness will never exceed an amount determined by subtracting from \$200,000.00 all amounts paid under the policy, including amounts paid under this endorsement.

**Additional Exclusions:** No benefits will be paid under this endorsement for loss or expense caused by, contributed to or resulting from:

1. Preferred Provider Room & Board which exceed 100% of Allowable Charges / \$300.00 per day;
2. Preferred Provider Hospital Miscellaneous Expenses which exceed 80% of Allowable Charges / \$1,500.00 aggregate maximum per day for Sickness and 80% of Allowable Charges for Injury;
3. Out of Network Room & Board which exceed 100% of Usual and Customary Charges / \$300.00 per day;
4. Out of Network Hospital Miscellaneous Expenses which exceed 60% of Usual and Customary Charges / \$1,500.00 aggregate maximum per day for Sickness and 60% of the Usual and Customary Charges for Injury;
5. Dental treatment;
6. Treatment of Mental and Nervous Disorder/Alcoholism and Substance Abuse in excess of the amounts specified in endorsement COL-90-KS END 8;
7. Outpatient Physiotherapy;
8. Services designated as "No Benefits" in the Basic Medical Expense Benefits Schedule of Benefits; and
9. Pre-existing Conditions except for individuals who have been continuously insured under the Optional Major Medical coverage for at least 8 consecutive months.

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**

Countersigned by: \_\_\_\_\_  
Licensed Resident Agent

# POLICY ENDORSEMENT

**In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:**

## COORDINATION OF BENEFITS PROVISION

### Definitions

- (1) **Allowable Expenses:** Any necessary, reasonable, and customary item of expense, a part of which is covered by at least one of the Plans covering the Insured Person.

An Allowable Expense to a Secondary Plan includes the value or amount of any Deductible Amount or Coinsurance Percentage or amount of otherwise Allowable Expenses which was not paid by the Primary or first paying Plan.

- (2) **Plan:** A group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care treatment benefits or services. Such group coverages include: (a) group or blanket insurance coverage whether insured or uninsured, or any other group type contract or provision thereof; this will not include group Hospital indemnity plans of \$100 per day or less or group accident only coverage; (b) service plan contracts, group or individual practices and other pre-payment group coverage; (c) any coverage under labor-management trustees plans, union welfare plans, employer and employee organization plans; and (d) coverage under governmental programs, including Medicare, and any coverage required or provided by statute.

- (3) **Primary:** The Plan which pays regular benefits.

- (4) **Secondary:** The Plan which pays a reduced amount of benefits which, when added to the Primary Plan's benefits will not be more than the Allowable Expenses.

**Effect on Benefits -** If an Insured Person has medical and/or drug coverage under any other Plan, all of the benefits provided are subject to coordination of benefits.

During any policy year or benefit period, the sum of the benefits that are payable by Us and those that are payable from another Plan may not be more than the Allowable Expenses.

During any policy year or benefit period, We may reduce the amount We will pay so that this reduced amount plus the amount payable by the other Plans will not be more than the Allowable Expenses. Allowable Expenses under the other Plan include benefits which would have been payable if a claim had been made.

However, if: (1) the other Plan contains a section which provides for determining its benefits after Our benefits have been determined; and (2) the order of benefit determination stated herein would require Us to determine benefits before the other Plan, then the benefits of such other Plan will be ignored in determining the benefits We will pay.

This Plan determines its order of benefits using the first of the following rules which applies:

- (1) If your other Plan does not have Coordination of Benefits, that Plan pays first.
- (2) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent.

### COORDINATION OF BENEFITS PROVISION (*Continued*)

- (3) Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (B)(3) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
- a. the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year; but
  - b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
- However, if the other Plan does not have the rule described in a. above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- (4) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
1. first, the Plan of the parent with custody of the child;
  2. then, the Plan of the spouse of the parent with the custody of the child; and
  3. finally, the Plan of the parent not having custody of the child.
- (5) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

**Right to Recovery and Release of Necessary Information** - For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this Provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

**Facility of Payment and Recovery** - Whenever payments which should have been made under our Coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this Provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**

Countersigned by: \_\_\_\_\_  
Licensed Resident Agent

# POLICY ENDORSEMENT

**In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:**

## **MENTAL AND NERVOUS DISORDER/ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT (PSYCHOTHERAPY)**

Benefits shall be provided for the treatment of Mental and Nervous Disorder, Alcoholism and Substance Abuse subject to all terms and conditions of the policy and the provisions of this endorsement.

Benefits shall not exceed a maximum of 30 days per policy year when such person is Hospital Confined for treatment of alcoholism, drug abuse or Mental or Nervous Disorders in a medical care facility licensed under the provisions of K.S.A. 65-429 and amendments thereto, a treatment facility for alcoholics licensed under the provisions of K.S.A. 65-4014 and amendments thereto, a treatment facility for drug abusers licensed under the provisions of K.S.A. 65-4605 and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b and amendments thereto or a psychiatric hospital licensed under the provisions of K.S.A. 75-3307b and amendments thereto.

Benefits for the treatment of Mental and Nervous Disorder, Alcoholism and Substance Abuse shall not exceed a maximum of 100% of the first \$100.00, 80% of the next \$100.00 and 50% of the next \$1,640.00 in any policy year, and limited to not more than \$7,500.00 in such person's lifetime, in the facilities enumerated when Hospital Confinement is not necessary for the treatment, or by a Physician licensed or Psychologist licensed to practice under the laws of the state of Kansas.

All expenses incurred for other or ancillary services stated on the Schedule of Benefits; and incurred as a result of Mental or Nervous Disorder are subject to the above stated daily and aggregate maximum(s).

For the purposes of this endorsement "Mental and Nervous Disorder" means disorders specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, 1994).

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**

Countersigned by: \_\_\_\_\_  
Licensed Resident Agent

# POLICY ENDORSEMENT

**In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:**

## **RESOLUTION OF GRIEVANCES**

You, the Insured, will be notified in writing by us if a claim or any part of your claim is denied. The notice will include the specific reason or reasons for the denial and the reference to the pertinent plan provision(s) on which the denial was based.

If you have a complaint about your claim denial, you may call our Member Services telephone number 1-800-767-0700 for further explanation to informally resolve your complaint. If you are not satisfied with our explanation of why the claim was denied, you, your authorized representative or provider may request an internal review of the claim denial. The following is our grievance review process:

- 1) The Insured must request in writing a benefit review within 60 days after the date that you receive the notice denying your claim. This will be an informal reconsideration review process of your claim by a Claims Supervisor. The Insured may not attend this review.
- 2) A decision will be made by the Claims Supervisor, within 30 days after the receipt of your request for review or the date all information required from the Insured is received.
- 3) If the Claims Supervisor denies the claim submitted for review and you are not satisfied with the explanation for the decision, you may request an external review pursuant to K.A.R. 40-4-42 et seq.

The Kansas Department of Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the Department at 420 SW 9<sup>th</sup> St., Topeka KS 66612 or by telephone at 1-800-432-2484.

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**

Countersigned by: \_\_\_\_\_  
Licensed Resident Agent

# POLICY ENDORSEMENT

**In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:**

## **PRE-ADMISSION NOTIFICATION**

The Company should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

**IMPORTANT:** Pre-notification is not a guarantee that benefits will be paid.

Value Check is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m. C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**

Countersigned by: \_\_\_\_\_  
Licensed Resident Agent